

<i>SERFF Tracking Number:</i>	<i>INGD-126259109</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>ReliaStar Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44048</i>
<i>Company Tracking Number:</i>	<i>154214</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.500 Other</i>
<i>Product Name:</i>	<i>154214 Individual Term Life Insurance Application</i>		
<i>Project Name/Number:</i>	<i>154214 Individual Term Life Insurance Application/154214</i>		

## Filing at a Glance

Company: ReliaStar Life Insurance Company

Product Name: 154214 Individual Term Life      SERFF Tr Num: INGD-126259109      State: Arkansas

Insurance Application

TOI: L04I Individual Life - Term      SERFF Status: Closed-Approved-      State Tr Num: 44048  
Closed

Sub-TOI: L04I.500 Other

Filing Type: Form

Co Tr Num: 154214

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Wendy Paquin, Terry

Disposition Date: 11/17/2009

Stumpf, Jackie Williams, EDS

EDSSupport, Laura Sampair

Date Submitted: 11/10/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 154214 Individual Term Life Insurance Application

Project Number: 154214

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/17/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 11/17/2009

Created By: Laura Sampair

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Wendy Paquin

Filing Description:

Insurance Commissioner

Department of Insurance

Compliance Life & Health

1200 West Third Street

Little Rock, Arkansas 72201-1904

SERFF Tracking Number: INGD-126259109 State: Arkansas  
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 44048  
Company Tracking Number: 154214  
TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other  
Product Name: 154214 Individual Term Life Insurance Application  
Project Name/Number: 154214 Individual Term Life Insurance Application/154214

Re: ReliaStar Life Insurance Company  
NAIC #67105 FEIN #41-0451140

Form Number:  
154214 Individual Term Life Insurance Application

Attention Policy Form Approval Division:

We submit the above referenced form for your review and approval.

The form does not replace any previously approved form.

The form does not contain any unusual or controversial items from the standpoint of industry standards.

The form will be available both in a printed and electronic format. The electronic format application presented to the customer for signature will appear on screen as a pdf of the filed application form containing all information completed by the customer, in appearance identical to the printed version. If an electronic signature will be used with an application, it will be obtained in compliance with applicable State and Federal law.

We have simultaneously filed the form in Minnesota, our state of domicile.

Please note we are submitting this filing simultaneously for Security Life of Denver Insurance Company.

The form will be used by licensed agents in the solicitation to the general public of our individual term life insurance products.

The form may be used with the following previously approved life application forms (approval date(s) provided) as well as our future life application portfolio:

153808 Individual Life Insurance Application Part II - Medical Declarations - 06/08/2009  
153795 Individual Life Insurance Application Part II - Medical Examination - 06/08/2009  
153794 Temporary Insurance Receipt - 06/08/2009  
153796 Children's Insurance Rider Application - 06/08/2009  
153813 Amendment to Application - 06/08/2009  
153849 Additional Statement to Application - 06/08/2009  
153836 Supplement to Individual Life Insurance Application - Alcohol Usage Questionnaire - 06/08/2009  
153837 Supplement to Individual Life Insurance Application - Aviation Questionnaire - 06/08/2009  
153838 Supplement to Individual Life Insurance Application - Drug Usage Questionnaire - 06/08/2009

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153839 Supplement to Individual Life Insurance Application - Foreign Travel or Residence Questionnaire - 06/08/2009  
153840 Supplement to Individual Life Insurance Application - Military Questionnaire - 06/08/2009  
153841 Supplement to Individual Life Insurance Application - Motor Sports Questionnaire - 06/08/2009  
153842 Supplement to Individual Life Insurance Application - Scuba Diving Questionnaire - 06/08/2009  
153843 Supplement to Individual Life Insurance Application - Tobacco/Nicotine Use Questionnaire - 06/08/2009  
153844 Supplement to Individual Life Insurance Application - Avocations and Professional Sports Questionnaire - 06/08/2009

Unless otherwise informed, we reserve the right to alter the layout of the enclosed form, including sequential ordering of the sections, color, and type font and size, and any changes necessary to comply with your state requirements, but we will only do so if such changes are within the allowable parameters or requirements set forth in your statutes.

To the best of our knowledge, the form complies with the laws and regulations of the insurance department of your state.

Sincerely,

Wendy Paquin, FLMI, CLU  
Senior Contract Analyst  
(612) 342-3595  
(612) 342-7531 (fax)  
wendy.paquin@us.ing.com

## Company and Contact

### Filing Contact Information

Laura Sampair, laura.sampair@us.ing.com  
20 Washington Ave South 612-342-7081 [Phone]  
Minneapolis, MN 55401 612-342-7081 [FAX]

### Filing Company Information

ReliaStar Life Insurance Company	CoCode: 67105	State of Domicile: Minnesota
20 Washington Avenue South	Group Code: 229	Company Type:
Minneapolis, MN 55401	Group Name:	State ID Number:
(860) 654-8065 ext. [Phone]	FEIN Number: 41-0451140	

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## Filing Fees

SERFF Tracking Number: INGD-126259109 State: Arkansas  
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 44048  
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Fee Required? Yes  
Fee Amount: \$125.00  
Retaliatory? Yes  
Fee Explanation: \$125 Per Filing (Higher Retaliatory Fee)  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	\$125.00	11/10/2009	31934197

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Linda Bird	11/17/2009	11/17/2009

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## Disposition

Disposition Date: 11/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Form</b>	Individual Term Life Insurance Application		Yes

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## Form Schedule

Lead Form Number: 154214

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	154214	Application/ Individual Term Life Enrollment Insurance Application Form	Initial		50.000	154214_1103 2009_StateFiled.pdf



# INDIVIDUAL TERM LIFE INSURANCE APPLICATION

☐ **ReliaStar Life Insurance Company**, 20 Washington Avenue South, Minneapolis, MN 55401

☐ **Security Life of Denver Insurance Company**, 1290 Broadway, Denver, CO 80203

A member of the ING family of companies

("the Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company opposes stranger-owned/stranger originated life insurance transactions ("STOLI") and will seek to terminate any such insurance coverage while retaining premiums paid, costs and/or damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section Q of the application.

## A. PRODUCT INFORMATION *(This application is for use with term products only.)*

1. Product Requested \_\_\_\_\_ 2. Face Amount \$ \_\_\_\_\_

3. Initial Term Period: ☐ 10 Year *(not available with all products)* ☐ 15 Year ☐ 20 Year ☐ 30 Year ☐ Other \_\_\_\_\_

## B. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Accidental Death Benefit Rider . . . . . \$ \_\_\_\_\_

☐ Waiver of Premium Rider

☐ Children's Insurance Rider

☐ Other \_\_\_\_\_

*(Complete Children's Insurance Rider Application.)*

☐ Other \_\_\_\_\_

## C. PROPOSED INSURED INFORMATION

1. First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

2. Birth Date \_\_\_\_\_ Birth State/Country \_\_\_\_\_ Gender: ☐ Male ☐ Female

3. E-mail \_\_\_\_\_ SSN or Government Issued ID Number \_\_\_\_\_

4. Daytime Phone (\_\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_\_) \_\_\_\_\_ Best Time to Call \_\_\_\_\_

6. Residence Address *(PO Boxes are not permitted.)* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

7. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)* . . . . . ☐ Yes ☐ No

8. Occupation/Duties \_\_\_\_\_

9. Employer \_\_\_\_\_ Employer Phone (\_\_\_\_\_) \_\_\_\_\_

10. Employer Address \_\_\_\_\_

11. Do you currently or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No

If "Yes", indicate Type \_\_\_\_\_ Amount & Frequency \_\_\_\_\_ Month/Year Last Used \_\_\_\_\_

12. Driver's License Number \_\_\_\_\_ 12. Driver's License State \_\_\_\_\_  
*(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)*

13. Name on Driver's License *(if different than above)* \_\_\_\_\_

## D. OWNER *(If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)*

1. Full Name of Owner/Trust/Corporation *(30 character limit)* \_\_\_\_\_

2. Owner Relationship to Proposed Primary Insured \_\_\_\_\_

3. Owner Birth Date \_\_\_\_\_ Owner Phone (\_\_\_\_\_) \_\_\_\_\_ Owner SSN/TIN \_\_\_\_\_

4. Owner Address *(PO Boxes are not permitted.)* \_\_\_\_\_

5. Corporation Contact Name \_\_\_\_\_

6. Address of Trust/Corporation \_\_\_\_\_

7. Billing Address \_\_\_\_\_

D. OWNER (Continued)

8. Type of Government Issued ID (Driver's License/Passport) \_\_\_\_\_ Document Number \_\_\_\_\_

Issuing State or Country \_\_\_\_\_ Issuance Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

9. Trust Contact Name \_\_\_\_\_ TIN \_\_\_\_\_ Trust Date \_\_\_\_\_

10. Purpose of the Trust \_\_\_\_\_ Type of Trust: ☐ Revocable ☐ Irrevocable

11. State of Incorporation \_\_\_\_\_ Trustee/Corporate Officer Name \_\_\_\_\_

12. Does the above trustee have sole authority to act on behalf of the Trust? . . . . . ☐ Yes ☐ No  
(If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)

E. PAYOR (Complete only if the payor is to be other than the owner.)

1. Payor Name \_\_\_\_\_

2. Payor Address (PO Boxes are not permitted.) \_\_\_\_\_

F. BENEFICIARY INFORMATION (Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)

1. Is the Beneficiary a Trust? . . . . . ☐ Yes ☐ No

2. Trust/Corporation Name \_\_\_\_\_ Trust Date \_\_\_\_\_ State of Incorporation \_\_\_\_\_

Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

G. PROPOSED INSURED PERSONAL HISTORY

1. Are you, or do you intend to become a member of the armed forces, including the Reserves, or on alert? (If "Yes", complete Military Questionnaire.) . . . . . ☐ Yes ☐ No

2. Do you intend to travel or reside outside the United States or Canada in the next two years? (If "Yes", complete Foreign Travel and Residence Questionnaire.) . . . . . ☐ Yes ☐ No

3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If "Yes", complete Aviation Questionnaire.) . . . . . ☐ Yes ☐ No

4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? (If "Yes", complete Avocations and Professional Sports Questionnaire.) . . . . . ☐ Yes ☐ No

5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? (If "Yes", complete Motor Sports Questionnaire.) . . . . . ☐ Yes ☐ No

6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? . . . . . ☐ Yes ☐ No

7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? . . . . . ☐ Yes ☐ No

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Explanation

## H. PAYMENT INFORMATION

1. Initial Payment Amount<sup>1</sup> \$ \_\_\_\_\_ Initial Payment: ☐ Check ☐ Cash on Delivery ☐ Credit Card ☐ EFT
2. Subsequent Payment Amount \$ \_\_\_\_\_ Subsequent Payments Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly<sup>2</sup>
- ☐ Military Allotment<sup>3</sup> (Active or retired military members must complete the Military Allotment form and return it to the military finance department.)
- ☐ Civil Service Allotment (The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)

<sup>1</sup> To draft the initial premium payment, complete Appendix E.

<sup>2</sup> To draft monthly payments, complete Section B of Appendix E.

<sup>3</sup> Two monthly premium payments are required before the policy becomes active.

## I. AUTOMATIC PREMIUM LOAN (APL) (Available with Endowment Benefit Products only.)

If you elect the APL Option, you direct the Company to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate.

☐ I elect the Automatic Premium Loan (APL) Option

## J. FUNDED ERISA INFORMATION (Complete if the policy will be owned by a "Funded ERISA Plan".)

Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? . . . ☐ Yes ☐ No

Plan Provider Name \_\_\_\_\_

☐ Tax-qualified plan (specify profit sharing, defined benefit, or defined contribution) \_\_\_\_\_

☐ Section 419/419A(f)(6) welfare benefit or VEBA plan ☐ Other (specify type and name of plan) \_\_\_\_\_

## K. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY (For a new List Bill plan, please contact the List Bill Department at 877-886-5050.)

1. Is the insurance employer-sponsored? ☐ Yes ☐ No List Bill/File Code Number (if plan already exists) \_\_\_\_\_

2. Employer Plan Name (if plan already exists) \_\_\_\_\_ 3. Phone (\_\_\_\_\_) \_\_\_\_\_

4. Address \_\_\_\_\_

## L. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes (If "Yes", review the policy backdating notice below.)

**POLICY BACKDATING NOTICE:** As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

**If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment.** You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

## M. FINANCIAL DETAILS

1. Is the applied-for policy in accordance with your insurance objectives and your anticipated financial needs? . . . . . ☐ Yes ☐ No
2. Do you believe you have the financial ability to continue making premium payments on this policy? . . . . . ☐ Yes ☐ No
3. Have you or your company ever declared bankruptcy? (If "Yes", provide details including date discharged.) . . . . . ☐ Yes ☐ No

### 4. Personal Insurance (For Personal Insurance complete questions 4-6; for Business Insurance complete questions 7-10.)

- ☐ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation
- ☐ Other \_\_\_\_\_

5. Annual Earned Income \$ \_\_\_\_\_ Annual Interest and Other Income \$ \_\_\_\_\_

6. Total Assets \$ \_\_\_\_\_ Total Liabilities \$ \_\_\_\_\_ Total Net Worth \$ \_\_\_\_\_

7. **Business Insurance:** ☐ Buy/Sell ☐ Key Person ☐ Other \_\_\_\_\_

8. Total Business Assets \$ \_\_\_\_\_ Total Business Liabilities \$ \_\_\_\_\_ Total Business Net Worth \$ \_\_\_\_\_

9. Business Net Profit After Taxes for Past Two Years: Last Year \$ \_\_\_\_\_ Previous Year \$ \_\_\_\_\_

M. FINANCIAL DETAILS (Continued)

10. Business Owner Name	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		\$	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	%	<input type="checkbox"/> Yes <input type="checkbox"/> No

N. IN FORCE/REPLACEMENT INFORMATION (Applies to both Owner and Proposed Insured. If a replacement is occurring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)

1. Do you currently have life insurance inforce or applied for? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.) . . . . .

Proposed Insured

Yes

No

Proposed Owner

Yes

No

☐☐ | ☐☐

Insured Name	Insurance Company (Do not include group policies.)	Policy Number	Amount	Date Issued

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes", complete state required replacement form and provide details below.) . . . . .

Proposed Insured

Yes

No

Proposed Owner

Yes

No

☐☐ | ☐☐

3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If "Yes", complete state required replacement form and provide details below.) . . . . .

Proposed Insured

Yes

No

Proposed Owner

Yes

No

☐☐ | ☐☐

4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

Insured Name	Insurance Company	Policy Number	Amount

O. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations from another insurance company.)

1. Insurance Company Name \_\_\_\_\_

2. Examination Date \_\_\_\_\_

3. To the best of your knowledge and belief, are the statements in the above examination true and complete today? . . .

Proposed Insured

Yes

No

Proposed Owner

Yes

No

☐☐ | ☐☐

4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? (If "Yes", please provide details below.) . . . . .

Proposed Insured

Yes

No

Proposed Owner

Yes

No

☐☐ | ☐☐

**P. REPLACEMENT VERIFICATION** *(For Agent use ONLY. If a replacement is occurring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)*

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? *(If "Yes", submit state required replacement forms.)* . . . . . ☐ Yes ☐ No
- a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*. . . ☐ Yes ☐ No
- b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form.)* . . . . . ☐ Yes ☐ No

Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Amount \$ \_\_\_\_\_

**Q. ING’S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)**

The Company, along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a “stranger”) that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions (“STOLI”) will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for “free” or at “no cost” or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as “non-recourse” lending arrangement where the lender’s sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding) ; or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered “prohibited conduct”.

**R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION**

**Representations and acknowledgements:** By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and represent that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

## R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION *(Continued)*

**By my signature below, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section Q above in connection with this application for insurance.**

**Authorization and Statements of Understanding:** I authorize the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes

Daytime phone number: (\_\_\_\_\_)\_\_\_\_\_.

Contact me between the hours of \_\_\_\_ a.m./p.m. and \_\_\_\_ a.m./p.m.

**By my signature below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:**

**Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

**Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

**All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703**

**I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.**

Proposed Owner Signed at (city/state) \_\_\_\_\_ Date \_\_\_\_\_

 Proposed Owner Signature (if other than the Insured) \_\_\_\_\_

Proposed Owner/Trustee Name (please print) \_\_\_\_\_

 Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if other than the owner & age 15 or older)

 Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if the Proposed Insured is a minor)

**By signing below I acknowledge that I have not engaged in prohibited conduct as described in Section Q, "ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)," nor am I aware of such conduct by the applicant**

 Writing Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Writing Agent Name (please print) \_\_\_\_\_

Writing Agent State Lic. Number \_\_\_\_\_ Writing Agent Number \_\_\_\_\_

SERFF Tracking Number: INGD-126259109 State: Arkansas  
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 44048  
Company Tracking Number: 154214  
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: 154214 Individual Term Life Insurance Application  
Project Name/Number: 154214 Individual Term Life Insurance Application/154214

## Supporting Document Schedules

		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Flesch Certification		
<b>Comments:</b>			
<b>Attachments:</b>			
	Flesch Readability Certification - RLIC.pdf		
	AR Certification Reg 19 - RLIC.pdf		
		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Application		
<b>Comments:</b>			
	This is an application filing and the application is attached to the Form Schedule tab.		
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Life & Annuity - Acturial Memo		
<b>Bypass Reason:</b>	Not applicable for this application filing.		
<b>Comments:</b>			

**RELIASTAR LIFE INSURANCE COMPANY**  
**Minneapolis, Minnesota**

**FLESCH READABILITY CERTIFICATE**

I certify that the Certificate form included in this submission has been printed in not less than ten point type.

The style, arrangement and overall appearance of the form gives no undue prominence to any portion of the text of the form.

The section titles are captioned in bold face type. The layout and spacing of the form separate the paragraphs from each other and from the border of the paper.

Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in this form.

**Flesch Scale Reading Ease Score**

I have supervised the computation of the Flesch scale reading ease score of this form, using the complete text of the form except for headings, indexes and tabular material, and the scores are listed below.

**Form Number**

**Flesch Reading Ease Scores**

154214

50.0

Signed



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Terry Stumpf  
Assistant Secretary

Date:

November 1, 2009



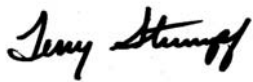
**ARKANSAS  
CERTIFICATION**

**Re:** 154214 Individual Term Life Insurance Application

We hereby certify that this submission meets the provisions of Regulation 19 and all applicable requirements of the Arkansas Insurance Department.

**ReliaStar Life Insurance Company**

By:

A handwritten signature in black ink, appearing to read "Terry Stumpf", written in a cursive style.

Terry Stumpf, Assistant Secretary

Date: November 1, 2009